MULTIDISCIPLINARY TEAM - ADDITIONAL INFORMATION FORM

12 years to 17 years 11 months
(adapted from HSE children's services referral form)

To be completed by the family along with the Service Request Form - Child

Individual Information

Surname:	First Name:	DOB:

Referrer Information

Name of Referrer:	Date:

Your child's Development (Please note some questions may not be relevant your child)

1. Movement (Gross Motor Skills)

Do you have any concerns about your child's ability to move around? (e.g. Walking, running, jumping, balancing)	Yes☐	No☐	Not sure☐

If yes, give details including any assistance required such as crutches, wheelchair for distance, etc.:

How does your child's difficulty with moving impact on his/her ability to do everyday tasks (e.g. leisure and social activities, washing, dressing) Please give details:

Have you noticed any recent changes in your child's ability to move or their level of fatigue?	Yes☐	No☐	Not sure☐

If yes, please give details:

2. Fine Motor and Hand Skills

Does your child have difficulty using their hands? (e.g. handwriting, using scissors, picking up small items, using computers)	Yes☐	No☐	Not sure☐

If Yes, please give details:

3. Sensory Processing

Is your child either unusually sensitive to, or does not notice noise, touch, texture, movement, smells, taste and colour?	Yes☐	No☐	Not sure☐

If yes, give details:

4. Daily Living Skills

Describe any other concerns you have about your child's daily activities? (See Section 4A-4E for daily activities for Eating and Drinking, Urine and Bowel habits, Personal Care and Dressing, Sleep and Rest, Breathing)

4A. Eating, Drinking and Swallowing

Does your child have special feeding requirements? (e.g. modified diet, thickened fluids)	Yes☐	No☐	Is your child on oral nutrition supplements?	Yes☐	No☐

Describe any concerns you have?

4B. Urinary and Bowel Habits (Continence)

Question			
Has your child any problems such as smearing, soiling, constipation, diarrhoea?		Yes☐	No☐
Does your child wear pads?	Yes☐	No ☐	Sometimes☐
Is your child prescribed any medications to assist with urinary and bowel issues?		Yes☐	No☐
Has he/she any particular urine problems? e.g. catheter?		Yes☐	No☐

If yes please describe:

4C. Personal Care, Dressing and Independence

Describe any concerns you have about your child's self-care skills such as organising belongings, managing money, managing his/her independence or safety awareness in the home/community?

4D. Sleep and Rest

Question			
Do you have concerns for your child's sleep or ability to rest/relax?	Yes☐	No☐	Not Sure☐
Does your child have difficulty initiating activities or appears lethargic or tire easily?	Yes☐	No☐	Not Sure☐

If Yes, please describe:

Does your child need any specialised equipment to aid a restful sleep?	Yes☐	No☐	Not Sure☐

If yes, please give details:

4E. Breathing (attach copies of any relevant reports, information and/or prescription)

Does your child experience respiratory difficulties? Yes☐ No☐	**And use the following:** Nebuliser☐ Home Oxygen☐ CPAP/Ventilation☐ Other☐

Please specify details:

5. Communication

How does your child express himself/herself (e.g. words, gestures, actions, picture exchange, Lámh, communication device)

Do you have any concerns about your child's ability to communicate?	Yes☐	No☐	Sometimes☐

If yes, please describe:

Does your child have difficulty expressing himself/herself (e.g. asking for help, describing events, holding a conversation)	Yes☐	No☐
Does your child have difficulty understanding people?	Yes☐	No☐
Does your child use any alternative or augmentative communication supports e.g. visuals, PECS, Lámh, device, communication board?	Yes☐	No☐

If yes to any of the above, please describe:

6. Behaviour and Emotions (attach copies of any relevant reports and information)

Have you concerns about your child's behaviour?	Yes☐	No☐	Sometimes☐
Is your child's behaviour difficult to manage at home?	Yes☐	No☐	Sometimes☐

Please describe:

Is your child's behaviour difficult to manage at school?	Yes☐	No☐	Sometimes☐

Please describe:

Do the following statements describe your child? (Please tick the appropriate boxes)

Anxious/Worries a lot ☐	**Aggressive ☐**	**Irritable/Frustrated☐**	**Gets upset for seemingly minor things☐**
Withdrawn/too quiet☐	**Doesn't like change☐**	**Over-reactive☐**	**Sad & Unhappy☐**
Upsetting language toward others☐	**Obsessional Behaviours/ Interests☐**	**Rapid Mood Swings☐**	**Will not comply with activities necessary for their health and wellbeing☐**

Please describe your concerns:

7. Social Interaction and Relationships, Play and Leisure

Do you have concerns about your child's ability to form and sustain relationships with others?	Yes☐	No☐	Not Sure☐

Please describe your concerns:

Please describe your child's participation in leisure or sport activities:

8. Learning and School			
Do you have any concerns about your child's ability to learn new skills?	Yes☐	No☐	Not Sure☐
Has anyone expressed any concern about your child's ability to learn? Teacher, Psychologist, Family, etc.	Yes☐	No☐	Not Sure☐
Do you have any concerns about your child's ability to concentrate?	Yes☐	No☐	Not Sure☐
If yes, please give details, including previous assessments:			

9. Eyesight and Hearing			
Have you concerns about your child's eye sight?	Yes☐	No☐	Not Sure☐
If yes, please describe level of visual impairment?			
Name of visiting teacher for visually impaired (if applicable):			
Have you concerns about your child's hearing?	Yes☐	No☐	Not Sure☐
If yes please describe level of hearing impairment?			
Name of visiting teacher for hearing impaired (if applicable):			

10. Pain			
Does your child experience any pain during movements? (e.g. rolling, crawling, walking)	Yes☐	No☐	Not sure☐
If yes, please give details:			

11. Additional Information / Comments